		FOR OHF USE					

LL1

2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0020925

Facility Name: North Adams Home

Address: Box 100 (Number) Mendon (City) 62351 (Zip Code)

County: Adams

Telephone Number: 217-936-2137 **Fax #** ( )

IDPA ID Number: 37-0978651001

Date of Initial License for Current Owners: 10-16-77

Type of Ownership:

x	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL		
	x	Charitable Corp.		Individual		State	
		Trust		Partnership		County	
IRS Exemption Code	501 c 3			Corporation		Other	
				"Sub-S" Corp.			
				Limited Liability Co.			
				Trust			
				Other			

In the event there are further questions about this report, please contact:
Name: James G. Hull **Telephone Number:** 217 228-1950

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 11/01/00 to 10/31/01 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title) James G. Hull, Vice President
(Firm Name & Address) WDM Computer Services, Inc., 1900 Harrison, Quincy IL 62301
(Telephone) 217 228-1950 Fax # 217-222-6053

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number North Adams Home # 0020925 Report Period Beginning: 11/01/00 Ending: 10/31/01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 08/09/99

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	115	Skilled (SNF)	115	41,975	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	115	TOTALS	115	41,975	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	2,461	1,550		4,011	8
9	SNF/PED					9
10	ICF	20,373	14,650		35,023	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	22,834	16,200		39,034	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.99%

D. How many bed-hold days during this year were paid by Public Aid? 70 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
Adult Day Care, Outpatient, P.T.

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [x]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [x] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 10/16/77

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [x]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [x] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [x] NO [ ]

Tax Year: 10/31/00 Fiscal Year: 10/31/00

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number North Adams Home # 0020925 **Report Period Beginning:** 11/01/00 **Ending:** 10/31/01

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	211,476	13,158	5,374	230,008		230,008		230,008			1
2	Food Purchase		177,416		177,416		177,416	(8,542)	168,874			2
3	Housekeeping	75,884	21,685		97,569		97,569		97,569			3
4	Laundry	102,775	16,895		119,670		119,670		119,670			4
5	Heat and Other Utilities			110,366	110,366		110,366		110,366			5
6	Maintenance	58,787	12,620	63,452	134,859		134,859		134,859			6
7	Other (specify):*			13,301	13,301		13,301		13,301			7
8	**TOTAL General Services**	448,922	241,774	192,493	883,189		883,189	(8,542)	874,647			8
	B. Health Care and Programs											
9	Medical Director			9,200	9,200		9,200		9,200			9
10	Nursing and Medical Records	1,400,415	71,317	11,115	1,482,847		1,482,847	(12,255)	1,470,592			10
10a	Therapy	59,951	1,193	5,923	67,067		67,067	(1,060)	66,007			10a
11	Activities	83,379	9,092		92,471		92,471	(40)	92,431			11
12	Social Services	43,362	195	3,995	47,552		47,552		47,552			12
13	Nurse Aide Training		108	413	521		521		521			13
14	Program Transportation	7,114		1,741	8,855		8,855	(2,745)	6,110			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,594,221	81,905	32,387	1,708,513		1,708,513	(16,100)	1,692,413			16
	C. General Administration											
17	Administrative	85,147			85,147		85,147		85,147			17
18	Directors Fees											18
19	Professional Services			51,682	51,682		51,682		51,682			19
20	Dues, Fees, Subscriptions & Promotions			47,785	47,785		47,785	(21,820)	25,965			20
21	Clerical & General Office Expenses	63,626	34,344		97,970		97,970	(475)	97,495			21
22	Employee Benefits & Payroll Taxes			295,329	295,329		295,329		295,329			22
23	Inservice Training & Education			1,400	1,400		1,400		1,400			23
24	Travel and Seminar			14,285	14,285		14,285		14,285			24
25	Other Admin. Staff Transportation			827	827		827		827			25
26	Insurance-Prop.Liab.Malpractice			53,127	53,127		53,127		53,127			26
27	Other (specify):* Contributions			775	775		775	(775)				27
28	**TOTAL General Administration**	148,773	34,344	465,210	648,327		648,327	(23,070)	625,257			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,191,916	358,023	690,090	3,240,029		3,240,029	(47,712)	3,192,317			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number North Adams Home #0020925 Report Period Beginning: 11/01/00 Ending: 10/31/01

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			175,063	175,063		175,063	(582)	174,481			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			124,830	124,830		124,830	(9,910)	114,920			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			2,318	2,318		2,318		2,318			35
36	Other (specify):*			4,603	4,603		4,603	(4,603)				36
37	**TOTAL Ownership**			306,814	306,814		306,814	(15,095)	291,719			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			2,074	2,074		2,074		2,074			38
39	Ancillary Service Centers		136,069	3,165	139,234		139,234	(4,500)	134,734			39
40	Barber and Beauty Shops		852	17,697	18,549		18,549		18,549			40
41	Coffee and Gift Shops		11,682		11,682		11,682		11,682			41
42	Provider Participation Fee		62,963		62,963		62,963		62,963			42
43	Other (specify):*			1,052	1,052		1,052	(452)	600			43
44	**TOTAL Special Cost Centers**		211,566	23,988	235,554		235,554	(4,952)	230,602			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,191,916	569,589	1,020,892	3,782,397		3,782,397	(67,759)	3,714,638			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number North Adams Home # 0020925 Report Period Beginning: 11/01/00 Ending: 10/31/01

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients	(1,060)	10a		2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(7,269)	2		4
5	Telephone, TV & Radio in Resident Rooms	(475)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(393)	30		9
10	Interest and Other Investment Income	(9,910)	32		10
11	Discounts, Allowances, Rebates & Refunds	(1,273)	2		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(452)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(775)	27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(21,660)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(24,492)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (67,759)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (67,759)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

North Adams Home

ID# 0020925

Report Period Beginning: 11/01/00

Ending: 10/31/01

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Private P.T. & Oxygen & Supplies	$ (12,255)	10	1
2	Pharmacy 3rd Party Revenue	(4,500)	39	2
3	Activity Program Revenue	(40)	11	3
4	Miscellaneous Exp.	(3,045)	36	4
5	Bank & Service Fees	(1,558)	36	5
6	Non-Care Related Depreciation	(189)	30	6
7	Private Bus Trips	(2,745)	14	7
8	Chamber of Commerce Dues	(160)	20	8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(24,492)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number North Adams Home # 0020925 **Report Period Beginning:** 11/01/00 **Ending:** 10/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(8,542)	0	0	0	0	0	0	0	0	0	0	(8,542)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(8,542)	0	0	0	0	0	0	0	0	0	0	(8,542)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(12,255)	0	0	0	0	0	0	0	0	0	0	(12,255)	10
10a	Therapy	(1,060)	0	0	0	0	0	0	0	0	0	0	(1,060)	10a
11	Activities	(40)	0	0	0	0	0	0	0	0	0	0	(40)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	(2,745)	0	0	0	0	0	0	0	0	0	0	(2,745)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(16,100)	0	0	0	0	0	0	0	0	0	0	(16,100)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(21,820)	0	0	0	0	0	0	0	0	0	0	(21,820)	20
21	Clerical & General Office Expenses	(475)	0	0	0	0	0	0	0	0	0	0	(475)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(775)	0	0	0	0	0	0	0	0	0	0	(775)	27
28	**TOTAL General Administration**	(23,070)	0	0	0	0	0	0	0	0	0	0	(23,070)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(47,712)	0	0	0	0	0	0	0	0	0	0	(47,712)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number North Adams Home # 0020925 **Report Period Beginning:** 11/01/00 **Ending:** 10/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(582)	0	0	0	0	0	0	0	0	0	0	(582)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(9,910)	0	0	0	0	0	0	0	0	0	0	(9,910)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	(4,603)	0	0	0	0	0	0	0	0	0	0	(4,603)	36
37	**TOTAL Ownership**	(15,095)	0	0	0	0	0	0	0	0	0	0	(15,095)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	(4,500)	0	0	0	0	0	0	0	0	0	0	(4,500)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(452)	0	0	0	0	0	0	0	0	0	0	(452)	43
44	**TOTAL Special Cost Centers**	(4,952)	0	0	0	0	0	0	0	0	0	0	(4,952)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(67,759)	0	0	0	0	0	0	0	0	0	0	(67,759)	45

Facility Name & ID Number North Adams Home # 0020925 Report Period Beginning: 11/01/00 Ending: 10/31/01

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [X] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number North Adams Home # 0020925 Report Period Beginning: 11/01/00 Ending: 10/31/01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number North Adams Home # 0020925 Report Period Beginning: 11/01/00 Ending: 10/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number North Adams Home # 0020925 Report Period Beginning: 11/01/00 Ending: 10/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Bank One		X	Mortgage	$17,461.00	8/23/97	$ 2,000,000	$ n/a	10/31/01	6.4400	$ 94,103	1
2	Caterpiller		X	Generator	$454.00	11/21/97	14,412	n/a	11/21/00	8.3120	3	2
3	First Banker's Trust		X	Mortgage	$17,461.00	10/23/01	1,466,855	1,466,855	02/23/11	6.2196	2,027	3
4	North Adams State Bank of Ursa		X	Cash Flow Loan Payoff	$3,248.55	03/16/01	250,000	220,546	03/31/04	9.0000	13,395	4
5	The Manifest Group		X	Equipment Purchase	$503.25	05/07/01	14,621	12,948	06/07/04	14.5000	843	5
	Working Capital											
6	North Adams State Bank of Ursa		X	Cash Flow	Interest	10/19/01	30,000	30,000	11/19/01	10.5000	121	6
7	First Banker's Trust		X	Cash Flow	Interest	03/16/04	150,000	150,000	03/16/04	5.5000	3,839	7
8	Bank One		X	Cash Flow	Interest	08/23/97	n/a	n/a	n/a	10.5000	10,499	8
9	TOTAL Facility Related				$39,127.80		$ 3,925,888	$ 1,880,349			$ 124,830	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 3,925,888	$ 1,880,349			$ 124,830	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number North Adams Home # 0020925 Report Period Beginning: 11/01/00 Ending: 10/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2000 report.	***Important***, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	1996	8
	1997	9
	1998	10
	1999	11
	2000	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME North Adams Home COUNTY Adams

FACILITY IDPH LICENSE NUMBER 0020925

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number North Adams Home # 0020925 Report Period Beginning: 11/01/00 Ending: 10/31/01

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 48,950 B. General Construction Type: Exterior Brick Frame Fire Resistant Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

North Adams Home, Inc. , Medical Clinic, 2567 Sq Ft
North Adams Home, Inc. , Cottages, 2756 Sq Ft

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Patient Care	435,600	1975	$ 22,893	1
2					2
3	TOTALS	435,600		$ 22,893	3

Facility Name & ID Number North Adams Home # 0020925 Report Period Beginning: 11/01/00 Ending: 10/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	88		1977	1977	$ 1,036,037	$ 25,944	40	$ 25,901	$ (43)	$ 620,920	4
5	1		1978	1978	2,633		10			2,633	5
6	10		1986	1986	438,224	14,673	30	14,607	(66)	223,021	6
7	10		1997	1997	1,374,932	34,442	40	34,373	(69)	156,731	7
8											8
	Improvement Type**										
9	Garage			1981	26,358	338	20	329	(9)	26,245	9
10	Building Improvement			1979	1,158					1,158	10
11	Building Improvement			1980	187					187	11
12	Building Improvement			1981	121					121	12
13	Building Improvement			1983	2,105					2,105	13
14	Building Improvement			1985	1,082					1,082	14
15	Land Improvement			1977	6,339					6,339	15
16	Land Improvement			1978	3,756					3,756	16
17	Land Improvement			1979	15,608					15,608	17
18	Land Improvement			1980	1,556					1,556	18
19	Land Improvement			1982	337					337	19
20	Land Improvement			1983	11,703					11,703	20
21	Land Improvement			1985	2,618					2,618	21
22	Land Improvement (IDPA)			1986	7,661					7,661	22
23	Generator			1979	11,412					11,412	23
24	Intercom System			1980	1,319					1,319	24
25	Fixed Equipment			1982	29,082					29,082	25
26	Building Improvement			1986	28,142	1,915	15	1,876	(39)	27,983	26
27	Building Improvement			1986	47,328	3,221	15	3,155	(66)	47,060	27
28	Building Improvement			1987	9,880	671	15	659	(12)	9,544	28
29	Building Improvement			1987	4,145	282	15	276	(6)	3,981	29
30	Building Improvement			1987	6,319	429	15	421	(8)	6,069	30
31	Building Improvement			1987	3,244	220	15	216	(4)	3,079	31
32	Land Improvement (IDPA)			1986	10,159					10,159	32
33	Land Improvement (IDPA)			1987	1,192					1,192	33
34	Land Improvement			1987	1,255					1,255	34
35	Wall Carpet			1988	12,374	838	15	825	(13)	11,257	35
36	Cabinets/doors			1988	5,316	266	20	266		3,522	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number North Adams Home # 0020925 Report Period Beginning: 11/01/00 Ending: 10/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Sprinklers	1988	$ 663	$ 27	25	$ 27	$	$ 351	37
38	Exhaust Fan/Door Locks	1988	2,151	143	15	143		1,876	38
39	Sidewalk & Sheltor Floor	1988	2,583		10			2,583	39
40	Land Improvements	1988	3,052		10			3,052	40
41	Patient Sensor System	1989	3,964		10			3,964	41
42	Dining Room Remodel	1989	3,943	263	15	263		3,220	42
43	Garage	1990	31,318	1,044	30	1,044		11,570	43
44	Parking Lot Paving	1990	10,500					10,500	44
45	Parking Lot Grading	1990	1,017					1,009	45
46	Roof repairs	1990	1,372	91	15	91		998	46
47	Land Improvements	1993	760	77	10	76	(1)	671	47
48	Roof	1991	82,210	4,128	20	4,111	(17)	42,997	48
49	Patio	1994	15,076	1,508	10	1,508		10,807	49
50	Electric Doors	1994	2,867	191	15	191		1,322	50
51	Storage Room	1995	1,662	111	15	111		720	51
52	Patient Sensor System	1996	2,340	236	10	234	(2)	1,316	52
53	Landscaping	1996	776	78	10	78		404	53
54	Carpet	1996	1,183	79	15	79		416	54
55	Ventilation	1996	1,154	77	15	77		386	55
56	Nursing Cabinets	1996	9,378	629	15	625	(4)	3,141	56
57	New Addition - Garden	1997	25,624	2,586	10	2,562	(24)	11,835	57
58	New Addition - Egress	1997	4,431	447	10	443	(4)	2,046	58
59	Laundry Remodel	1997	13,967	936	15	931	(5)	3,823	59
60	Re-roof	1998	5,232	349	15	349		1,206	60
61	Alarm System	1999	2,466	164	15	164		411	61
62	Roof repairs	1999	11,000	733	15	733		1,833	62
63	Lanscaping	1999	992	99	10	99		215	63
64	Shower Remodel	1999	2,792	141	20	140	(1)	246	64
65	Power Door (scu)	2000	1,233	123	10	123		195	65
66	New Railing	2000	670	67	10	67		100	66
67	Fire Wall	2000	21,922	1,096	20	1,096		1,370	67
68	Oxygen Room	2000	2,409	120	20	120		151	68
69	Dampers	2000	2,581	172	15	172		215	69
70	TOTAL (lines 4 thru 69)		$ 3,376,870	$ 98,954		$ 98,561	$ (393)	$ 1,375,644	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number North Adams Home # 0020925 Report Period Beginning: 11/01/00 Ending: 10/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 3,376,870	$ 98,954		$ 98,561	$ (393)	$ 1,375,644	1
2	Duct Detectors	2000	2,285	228	10	228		286	2
3	Emergency Lighting	2000	2,119	212	10	212		265	3
4	Smoke/Fire Dampers	2000	1,300	130	10	130		152	4
5	Emergency Lighting	2000	801	80	10	80		94	5
6	Roof Recoating	2001	28,450	632	15	632		632	6
7	Carpet for special care unit	2001	1,780	45	10	45		45	7
8	Concrete to lift room	2001	1,900	24	20	24		24	8
9	Remodel 8 Rooms	2001	11,757	65	15	65		65	9
10	Fencing	2001	877	22	10	22		22	10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,428,139	$ 100,392		$ 99,999	$ (393)	$ 1,377,229	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number North Adams Home # 0020925 Report Period Beginning: 11/01/00 Ending: 10/31/01

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 635,817	$ 62,212	$ 62,212	$	5-15	$ 325,968	71
72	Current Year Purchases	67,681	4,690	4,690		8	4,690	72
73	Fully Depreciated Assets	209,053				5-15	209,053	73
74								74
75	TOTALS	$ 912,551	$ 66,902	$ 66,902	$		$ 539,711	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Transportaion	1980 Ford Van	1990	$ 45,725	$	$	$	5	$ 45,725	76
77	Patient Transportaion	Bus	1999	37,900	7,580	7,580		5	15,792	77
78										78
79										79
80	TOTALS			$ 83,625	$ 7,580	$ 7,580	$		$ 61,517	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 4,447,208	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 174,874	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 174,481	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (393)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,978,457	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Cottage #1	$ 75,325	$ 2,404	$ 48,277	86
87	Medical Clinic	176,944	5,684	114,898	87
88	Land Trust	49,865			88
89	Beauty & Barber	1,234		1,234	89
90	See Attatched List	428,869	12,714	111,958	90
91	TOTALS	$ 732,237	$ 20,802	$ 276,367	91

G. Construction-in-Progress

	Description	Cost	
92	Hospice Room Remodel	$ 832	92
93			93
94			94
95		$ 832	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number North Adams Home # 0020925 Report Period Beginning: 11/01/00 Ending: 10/31/01

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: $ 2,318 Description: O2 Concentrators & Nebulizers
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number North Adams Home # 0020925 Report Period Beginning: 11/01/00 Ending: 10/31/01

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [X]
- HOURS PER AIDE 99

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [X]
- HOURS PER AIDE 56

B. EXPENSES

ALLOCATION OF COSTS (d)

			1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition		$	$ 413	$	$ 413
2	Books and Supplies			108		108
3	Classroom Wages	(a)				
4	Clinical Wages	(b)				
5	In-House Trainer Wages	(c)				
6	Transportation					
7	Contractual Payments					
8	Nurse Aide Competency Tests					
9	TOTALS		$	$ 521	$	$ 521
10	SUM OF line 9, col. 1 and 2	(e)	$ 521			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number North Adams Home # 0020925 **Report Period Beginning:** 11/01/00 **Ending:** 10/31/01

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 10/31/01 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ (103,403)	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	442,532		3
4	Supply Inventory (priced at FIFO)	37,803		4
5	Short-Term Investments			5
6	Prepaid Insurance	15,921		6
7	Other Prepaid Expenses	4,710		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 397,563	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	272,459		12
13	Land	72,758		13
14	Buildings, at Historical Cost	4,087,461		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	990,150		16
17	Accumulated Depreciation (book methods)	(2,225,741)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe C-I-P	832		22
23	Other(specify): Bond Refinancing	29,013		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 3,226,932	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,624,495	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 137,002	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	180,000		29
30	Accrued Salaries Payable	153,511		30
31	Accrued Taxes Payable (excluding real estate taxes)	718		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation	210,969		34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Payroll Ded. Liabilities	35		36
37	Accrued Interest Payable	2,478		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 684,713	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	233,494		39
40	Mortgage Payable	1,466,855		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,700,349	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,385,062	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,239,433	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,624,495	$	48

***(See instructions.)**

Facility Name & ID Number North Adams Home # 0020925 Report Period Beginning: 11/01/00 Ending: 10/31/01

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,322,345	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,322,345	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(80,740)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) **Cottages (Net Income)**	2,351	15
16	Other (describe) **Medical Clinic (Net Loss)**	(4,523)	16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (82,912)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,239,433	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number North Adams Home # 0020925 Report Period Beginning: 11/01/00 Ending: 10/31/01

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,422,477	1
2	Discounts and Allowances for all Levels	(6,886)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,415,591	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	8,493	6
7	Oxygen	2,289	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 10,782	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	7,284	12
13	Barber and Beauty Care	21,138	13
14	Non-Patient Meals	7,269	14
15	Telephone, Television and Radio	475	15
16	Rental of Facility Space		16
17	Sale of Drugs	135,822	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	1,276	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 173,264	23
	D. Non-Operating Revenue		
24	Contributions	44,388	24
25	Interest and Other Investment Income***	9,277	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 53,665	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Transportation Income	14,344	28
28a	See List Attatched	34,011	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 48,355	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,701,657	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	883,189	31
32	Health Care	1,708,843	32
33	General Administration	647,997	33
	B. Capital Expense		
34	Ownership	306,814	34
	C. Ancillary Expense		
35	Special Cost Centers	172,591	35
36	Provider Participation Fee	62,963	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,782,397	40
41	**Income before Income Taxes (line 30 minus line 40)****	(80,740)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (80,740)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number North Adams Home # 0020925 Report Period Beginning: 11/01/00 Ending: 10/31/01

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,068	2,133	$ 46,138	$ 21.63	1
2	Assistant Director of Nursing	2,017	2,123	39,209	18.47	2
3	Registered Nurses	11,468	12,334	191,935	15.56	3
4	Licensed Practical Nurses	30,640	32,420	406,400	12.54	4
5	Nurse Aides & Orderlies	71,640	74,526	679,402	9.12	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,257	5,578	59,951	10.75	8
9	Activity Director	1,932	2,088	22,972	11.00	9
10	Activity Assistants	8,541	9,044	60,407	6.68	10
11	Social Service Workers	4,001	4,152	43,362	10.44	11
12	Dietician					12
13	Food Service Supervisor	2,088	2,174	22,762	10.47	13
14	Head Cook	1,720	1,845	16,296	8.83	14
15	Cook Helpers/Assistants	12,475	13,075	85,500	6.54	15
16	Dishwashers	12,550	13,232	86,918	6.57	16
17	Maintenance Workers	5,684	6,046	58,787	9.72	17
18	Housekeepers	9,573	10,138	75,884	7.49	18
19	Laundry	10,245	11,136	102,775	9.23	19
20	Administrator	1,635	2,178	51,112	23.47	20
21	Assistant Administrator	2,080	2,153	34,035	15.81	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,085	6,493	63,626	9.80	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,261	3,540	37,331	10.55	31
32	Other Health Care(specify)					32
33	Other(specify)	790	790	7,114	9.01	33
34	TOTAL (lines 1 - 33)	205,750	217,198	$ 2,191,916 *	$ 10.09	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	161	$ 5,374	1-3	35
36	Medical Director				36
37	Medical Records Consultant	16	1,080	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	96	3,165	10-3	39
40	Physical Therapy Consultant	97	5,523	10a-3	40
41	Occupational Therapy Consultant	5	310	10a-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	1	90	10a-3	43
44	Activity Consultant				44
45	Social Service Consultant	69	3,995	12-3	45
46	Other(specify) Accounting	11	443	19-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	455	$ 19,980		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses	402	10,150	10-3	51
52	Nurse Aides	9	161	10-3	52
53	TOTAL (lines 50 - 52)	411	$ 10,311		53

Facility Name & ID Number North Adams Home # 0020925 Report Period Beginning: 11/01/00 Ending: 10/31/01

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
John Bainum	Administrator	.00	$ 51,112
Greg Sandidge	Asst. Admin.	.00	34,035
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 85,147

B. Administrative - Other

Description	Amount
N/A	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
WDM Computer	Accounting/Support	$ 29,690
Hubert Staff	Legal	4,505
Arnolds, Behrens, Deters, & Grey	Audit	6,643
Kathie Palmer	Lie Detector Test	34
Bank One	Appraisal Fee	4,400
Blackman, Kallick, Bartelstein	Consultant Fee	500
Architechnics	Consultant Fee	332
Accu-Med Services	Software Support/Training	5,136
ComputerLand	Software Training	293
Intuit	Software Support	149
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 51,682

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 86,909
Unemployment Compensation Insurance	12,411
FICA Taxes	162,841
Employee Health Insurance	32,948
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Physicals	220
TOTAL (agree to Schedule V, line 22, col.8)	$ 295,329

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
N/A		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	15,958
Health Care Worker Background Check	276
(Indicate # of checks performed 23)	
Public Relations/Advertising	21,719
LSN Membership/Dues	4,873
MES of IL	1,375
EBC Fees	1,680
Fed. Reg. Guides	312
See List Attatched	1,592
Less: Public Relations Expense	(3,921)
Non-allowable advertising	(17,899)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 25,965

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
See List Attatched	14,285
Seminar Expense	
Entertainment Expense	( )
(agree to Sch. V,	
TOTAL line 24, col. 8)	$ 14,285

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number North Adams Home # 0020925 Report Period Beginning: 11/01/00 Ending: 10/31/01

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number North Adams Home **#** 0020925 **Report Period Beginning:** 11/01/00 **Ending:** 10/31/01

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **See List Attatched**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? _____

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **8.16**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **30,902** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. _____

(9) Are you presently operating under a sublease agreement? _____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

_____

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **62,963**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **Yes** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **N/a** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **7,269**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **Yes** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **3,724**
c. What percent of all travel expense relates to transportation of nurses and patients? **92%**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ _____

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Arnolds, Behrens Deters & Gray** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **Yes** If no, please explain. _____

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.

North Adams Home, Inc. 0020925
11/01/00 thru 10/31/01
Line 24, Schedule XVII Sec. E

Endowment funds	$21,539.00
Donated cash	$4,835.00
Memberships	$2,627.00
Future Development Fund	$3.00
Hospitality Room Fund	$1,357.00
Mini fair income	$8,227.00
Van fund donations	$759.00
Religious income	$5,041.00
	$44,388.00

Line 28a, Schedule XVII Sec. E

Gain on sale of Asset	$609.00
Discounts	$469.00
Rebates	$804.00
Admission income	$2,460.00
Activities income	$40.00
Respite Care	$802.00
Misc. income	$4,302.00
Personal Purchases Income	$1,875.00
Sale of Supplies to Employees	-$19.00
Private Ancillary Rev. (Supplies)	$22,669.00
	$34,011.00

Schedule XIX, Sec F

IL Act. Assoc. Dues	$55.00
NAEIR Dues	$575.00
Quincy Herald Whig	$285.00
Clement Comm. Newsletter	$58.00
Progressive Business Mag.	$249.00
Elliot Publishing	$12.00
NursingAid Mag.	$25.00
Chamber Of Commerce	$160.00
Annual Report Fee	$5.00
IL Carity Fund Fee	$15.00
Secretary Of State	$48.00
INAA Membership Dues	$75.00
Notary Fee	$30.00
	$1,592.00

Sch. XX Question #2

a. Life Services Network	$4,873.00
b. Il. Nursing Home Admin. Assoc.	$75.00
c. Il Activity Assoc. Dues	$55.00
	$5,003.00

Line 25, Schedule V

	Line 25
Repairs & Maint. Mini Bus	$21.00
Repairs & Maint. Bus	$117.00
Gas & Oil Mini Bus	$134.00
Gas & Oil Bus	$52.00
Mini Bus Misc Exp.	$2.00
Bus Misc Exp.	$4.00
Employee Business Travel	$497.00
	$827.00

Line 36, Schedule V

Amortization of refinancing loan fees	$3,045.00
Bank & service fees	$1,558.00
	$4,603.00

Line 6, Schudule V

Repairs & maint. Dietary	$4,551.00
Repairs & maint. Laundry	$428.00
Repairs & maint. Bldgs	$15,926.00
Repairs & maint. Equip.	$18,193.00
Repairs & maint. Grounds	$6,713.00
Repairs & maint. Office	$4,045.00
Repairs & maint. Bldgs for Life Safety Code	$9,085.00
Outside services	$4,511.00
	$63,452.00

Line 7, Schudule V

Waste Removal	$8,121.00
Exterminator	$5,180.00
	$13,301.00

Line 43, Schudule V

Bad Debts	$600.00
Sales Tax	$452.00
	$1,052.00

SEMINAR TRAVEL
NOV. 2000-OCT. 2001

Name: Shattering of the Myths
Attended By: Greg Sandidge
Date: November 7, 2000
Registration $ 35.00 $ 35.00

Name: Food & Equipment Trade Show
Given By: Bunn Capitol
Place: Springfield, Il
Date: November 8, 2000
Attended By: Greg, John, Teresa, Cathy
Gas $ 35.21
Meals & Parking $ 11.28
$ 46.49 $ 81.49

Name: Public Health Issues
Given By: Bank One (Todd Hoovermale)
Place: Springfield, Il.
Date: November 13, 2000
Attended By: Greg & John
Gas $56.00 $ 137.49

Name: Womans Health Issues
Place: John Wood Community College
Given By: John Wood College
Date: November 28, 2000
Attended By: Kathy Archambo,Jeanne Thomas, Kay & Lisa
Registration $ 130.00 $ 267.49

Name: Review Course for Nursing Home Administrators
Given By: Illinois Health Care Association
Place: Hilton Hotel, Springfield, Il
Date: November 29, 30, 2000
Attended By: Greg Sandidge
Registration $ 500.00
Motel $ 149.00
Meals $ 42.98
Supplies $ 14.71
Testing $ 5.50
Mileage & Parking $ 87.28
$ 799.47 $ 1,066.96

Name: LSN Nurse Leadership Retreat
Given By: Life Service Network
Date: November 29-December 1, 2000
Place: Galena, Il.
Attended By: Kay & Lisa
Registration & Motel $ 790.00
Mileage $ 154.60
Meals $ 46.26
Tips $ 8.00
Gas $ 17.60
$ 1,016.46 $ 2,083.42

Name: IDPH Meeting
Date: January 18, 2001
Attended By: Greg & John
Place: Peoria, Il.
Meals $ 44.56
Gas $ 59.37
$ 103.93 $ 2,187.35

Name: Dietary Sanitation Training
Place: Springfield, Il.
Date: February 6, 2001, February 13, 2001
Attended By: Dianne Mann, Gina Troutner
Registration $ 190.00 $ 2,377.35

Name: Access Computer Seminar
Place: Computerland, Quincy, Il
Date:
Attended By: Greg, Beulah, Dianne
Cost $ 490.00 $ 2,867.35

Name: The D'S of Alzheimers
Place: Blessing Conference Center, Quincy, Il
Date: March 6, 2001
Attended By: Pat Walter, Kas M., Lisa B. Mary B., Kay M.
Registration $ 125.00 $ 2,992.35

Name: Resource Training
Place: Columbus, Ohio
Attended By: Greg & Mae
Date: March 6, 2001
Airfare $ 173.00
Mileage $ 146.20
Motel $ 319.48
Meals $ 115.86
Misc. $ 10.00
Tips $ 20.50
Rent-a-car $ 129.63
$ 914.67 $ 3,907.02

Name: Minimum Data Set & Resident Assessment Protocols
Place: Springfield, Il
Date: March 26, 3001
Given By: The Institute
Attended By: Holly, Regina, Sandy, Lisa, Kay, John
Registration $ 695.00
Meals $ 92.45
$ 787.45 $ 4,694.47

Name: Wound Care Symposium
Place: Regional Burn Center, Springfield, Ill.
Attended By: Kay & Lisa
Date: March 27, 2001
Registration $ 150.00
Mileage $ 72.80
Motel $ 82.50
$ 305.30 $ 4,999.77

Name: Powerpoint Class
Given By: Computerland, Quincy
Attended By: Greg
Date: March 27, 28, 2001
Cost $ 100.00 $ 5,099.77

Name: INHAA Convention & Trade Show
Place: Springfield, Il
Date: March 28, 29, 2001
Attended By: John Bainum
Registration $ 95.00
Motel $ 206.80
Mileage $ 75.32
Meals $ 30.40
Gas $ 18.50
$ 426.02 $ 5,525.79

Name: Long Term Care Meeting
Place: Ritz, Quincy, Il
Date: March 29, 2001
Attended By: Lisa & Kay
Meals $ 50.00 $ 5,575.79

Name: Trade Show
Given By: Bunn Capitol
Date: March 30, 2001
Attended By: Greg, Teresa, Cathy
Place: Springfield, Il
Mileage $ 35.00 $ 5,610.79

Name: Updating the Illinois LTC Ombudsman Program Standards
Given By: State Of Il. Dept. on Aging
Place: Bloomington, Il
Date: March 30, 2001
Attended By: Greg
Mileage $ 35.00 $ 5,645.79

Name: Staff Retention
Given By: Denman Pharmacy
Date: April 3, 2001
Attended By: Lisa, Kay, Kathy, Mary, John & Greg

Name: Art of Low Functioning Activity Program
Place: Springfield, Il
Attended By: Gay Andrew
Given By: Il. Health Care Ass'n.
Date: April 4, 2001
Registration $ 160.00 $ 5,805.79

Name: Administrators License Testing
Place: Springfield, Il
Attended By: Greg Sandidge
Date: April 10, 11, 2001
Motel $ 73.70
Mileage $ 67.20
Meals $ 28.06
$ 168.96 $ 5,974.75

Name: Excell Classes
Place: Computerland, Quincy, Il
Date: April 18, 2001
Attended By: Greg & Dianne
Cost $ 200.00 $ 6,174.75

Name: NHRMA Meeting
Attended By: Greg
Date: April 25, 2001
Place: Normal, Il
Mileage $ 106.68
Meals $ 13.78
$ 120.46 $ 6,295.21

Name: NHRMA Meeting
Attended By: Greg, Beulah & Dianne
Date: April 30, 2001
Place: Peoria, Il
Gas $ 50.00 $ 6,345.21

Name: Access Advance
Place: Computerland, Quincy, Il
Date: May 8, 2001
Attended By: Greg
Registration $ 140.00 $ 6,485.21

Name: Achieving Success in Diet & Nutrition
Given By: Il. Health Care Ass'n.
Place: Springfield, Il
Date: May 9, 2001
Attended By: Teresa, Cathy
Registration $ 320.00
Gas $ 21.00
$ 341.00 $ 6,826.21

Name: Resident Assessment Protocals
Given By: The Institute
Date: May 11, 01
Attended By: Sandy, Greg, Regina, Lisa
Place: Springfield, Il
Meals $ 93.15 $ 6,919.36

Name: Restaurant & Food Show
Place: Chicago, Il
Date: May 20, 21, 2001
Attended By: Greg, Cathy, Teresa, Dianne, Gina
Train $ 438.00
Hotel $ 346.69
Meals, Tips, etc. $ 264.80
Registration $ 240.00
$ 1,289.49 $ 8,208.85

Name: Excel Class
Attended By: Cathy, Lisa, Greg,
Place: Computerland, Quincy, Il
Date: May 22, 2001
Cost $ 400.00 $ 8,608.85

Name: Abuse In Long Term Care
Place: Illinois Veterans Home
Date: May 23, 2001
Attended By: Sandy, Kay, John
Registration $ 90.00
Meals $ 17.93
$ 107.93 $ 8,716.78

Name: Building A Theurapeutic Program
Given By: Alzheimers Association
Date: June 18, 2001
Place: Metamora, Il
Registration $ 75.00
Meals $ 13.52
$ 88.52 $ 8,805.30

Name: A Vision for The Future
Given By: Il. Ass'n. of Long Term Care Ombudsman
Date: June 22, 2001
Attended By: John
Place: Quincy Senior Center, Quincy, Il
Registration $ 40.00
Processing Fee $ 10.00
$ 50.00 $ 8,855.30

Name: Your Medicaid Rate: Is It The Highest It Can Be
Given By: Life Services Network
Date: June 27, 2001
Place: Morton, Il
Attended By: Greg, Dianne, Kay
Registration $ 285.00
Meals & Tips $ 53.54
Mileage $ 121.52
$ 460.06 $ 9,315.36

Name: Steps to Effective Compliant Care Plans
Given By: The Institute
Date: June 26, 2001
Place: Springfield, Il
Attended By: Greg, Cathy, Sandee, Marcy, Holly, Regina, Teresa, Gay
Registration $ 834.00
Gas $ 37.65
Meals $ 73.52
$ 945.17 $ 10,260.53

Name: Supervisory Safety Management Tools
Given By: John Wood
Place: John Wood Annex, Quincy
Date: July 10, 2001
Attended By: Greg, Gene, Beulah
Registration $ 90.00
Meals $ 21.56
$ 111.56 $ 10,372.09

Name: IAPA Workshop
Given By: Illinois Activity Professionals Ass'n.
Date: July 20, 2001
Attended By: Gay
Place: Decatur, Il
Registration $ 40.00 $ 10,412.09

Name: Pioneer Concept LTC Coalition Training

Given By: West Central Il. Case Coordination Unit			
Attended By: Gay			
Place: Chicago, Il			
Date: July 23, 2001			
	Train	$ 81.00	
	Hotel	$ 149.37	
	Meals & Tips	$ 53.72	
		$ 284.09	
	Reimbursed	$ (262.37)	$ 10,433.81
Name: How to Develop and Administer A Budget			
Place: Springfield, Il			
Attended By: Greg & Dianne			
Date: July 25, 2001			
	Registration	$ 390.00	
	Mileage	$ 80.78	
	Meals & Tips	$ 18.75	
		$ 489.53	$ 10,923.34
Name: Administrator License Testing			
Attended By: Greg Sandidge			
Date: July 27, 2001			
Place: Dekalb, Il			
	Registration	$ 130.00	
	Motel	$ 137.38	
		$ 267.38	$ 11,190.72
Name: Social Service Workshop			
Attended By: Sandy & Verna			
Date: August 10, 2001			
Place: Springfield, Il			
	Registration	$ 150.00	
	Meals	$ 39.20	
		$ 189.20	$ 11,379.92
Name: Excell Class			
Place: Computerland, Quincy			
Date: August 21, 2001			
Attended By: Greg & Diann			
	Cost	$ 200.00	$ 11,579.92
Name: Activity Adie Inservice Training			
Place: Sunset Home, Quincy, Il			
Date: August 24, 2001			
Given By: Cara Bainum			
Attended By: John, Doris, Patty, Mary, Helen, Kas			
	Registration	$ 150.00	$ 11,729.92
Name: QuickBooks Pro			
Given By: John Wood Community College			
Date: August 28, 2001			
Attended By: Greg, Beulah, Dianne			
	Cost	$ 150.00	$ 11,879.92
Name: INHAA Conference			
Attended By: John, Greg			
Place: Stoney Creek Inn, East Peoria			
Date: August 28, 30, 2001			
	Registration	$ 130.00	
	Gas	$ 18.35	
	Auto Rental	$ 141.30	
	Motel	$ 324.53	
	Meals & Tips	$ 22.73	
		$ 636.91	$ 12,516.83
Name: First Aid Course			
Given By: John Wood College			
Date: September 12, 2001			
Attended By: Holly & Lisa			
	Registration	$ 180.00	$ 12,696.83
Name: PRA Course			
Given By: John Wood Community College			
Attended By: Tisha Hibbert			
Date: September 17, 2001			
	Registration	$ 33.00	$ 12,729.83
Name: AAA Long Range Planning Meeting			
Place: Jumers, Normal, Il			
Attended By: Greg Sandidge			
Date: September 19, 2001			
	Mileage & Gas	$ 100.79	
	Meals	$ 8.13	
		$ 108.92	$ 12,838.75
Name: Il. Activity Professional Ass'n.			
Place: Macomb, Il			
Date: September 24, 2001			
Attended By: Gay			
	Meals	$ 24.64	$ 12,863.39
Name: LSN Fall Institute			
Attended By: Greg, Lisa, Kay			
Date: September 24, 25, 26, 2001			
Place: Springfield, Il.			
	Auto Rental	$ 174.76	
	Gas	$ 41.31	
	Motel	$ 158.74	
	Meals, Tips	$ 106.51	
	Registration	$ 595.00	
		$ 1,076.32	$ 13,939.71
Name: Il, Activity Professionals			
Place: Decatur, Il			
Date: October 3, 2001			
Attended By: Gay			
	Registration	$ 130.00	
	Motel	$ 83.60	
	Meals	$ 25.11	
	Books	$ 24.89	
		$ 263.60	$ 14,203.31
Name: Sav-a-day Washer Seminar			
Place: St. Louis, Mo.			
Attended By: Gene & Ed			
Date: October 25, 2001			
	Meals	$ 27.43	
	Gas	$ 19.75	
		$ 47.18	$ 14,250.49
Name: Shattering of Myths			
Given By: Gerontology Committee			
Attended By: Ruth Shupe			
Date: October 31, 2001			
	Registration	$ 35.00	$ 14,285.49 Total

North Adams Home Board of Directors as of 10/31/01

Name	Address	City	State	Zip
Beeler, Russell	320 N Hwy 96	Sutter	IL	62373
Burke, Carroll	1573 Hwy 61	Loraine	IL	62349
Butler, Gary	2948 East 1000th St	Mendon	IL	62351
Ehrhardt, Brenda	PO Box 223	Mendon	IL	62351-0223
Finlay, Mike	RR #1 box 129 C	Mendon	IL	62351
Frese, Lawrence H.	2149 E 1200th St	Mendon	IL	62351
Hemming, Dean	PO Box 33	Ursa	IL	62376
Hibbert, Ron	PO Box 206	Mendon	IL	62351
Husemann, Ronald	1617 N 1600th Ave	Fowler	IL	62338
King, Sherri	RR #1 Box 42 A	Mendon	IL	62351
Kircher, Kathleen J.	605 S State Rd.	Mendon	IL	62351
McCleary, Judy	1276 N 2250th Ave	Mendon	IL	62351
Owens, Larry	1603 N 1950th Ave	Paloma	IL	62359
Spohr, Edith	7211 N 96th St	Fowler	IL	62338

* Ron Huseman provides some woodworking and carpentry work.
* Kathy Kircher provides pamphlets.

Cottage Sewer	$839.00	$21.24	$129.21
Cottage Sewer	$24,101.00	$603.96	$4,273.49
Cottage Equip	$5,450.00	$363.36	$2,876.60
Land Imp.	$6,860.00	$0.00	$0.00
Land Imp.	$6,455.00	$0.00	$0.00
Chapel Equip	$11,023.00	$47.52	$10,120.22
Cottages	$82,066.00	$2,672.04	$32,740.76
Parking Lot	$10,300.00	$0.00	$10,300.00
Cottage	$127,973.00	$4,290.00	$37,884.32
Alarm System	$1,650.00	$110.04	$962.85
Appliances	$1,159.00	$0.00	$1,159.00
Carpet	$1,320.00	$88.02	$659.85
Carpet	$2,110.00	$141.59	$742.11
Carpet	$1,070.00	$72.60	$392.53
Carpet	$1,145.00	$76.80	$402.56
Shelves	$500.00	$68.20	$491.43
Range	$660.00	$134.10	$525.90
Refrigerator	$654.00	$130.80	$337.90
Cottage	$137,600.00	$3,432.84	$7,152.35
Carpet	$1,388.00	$92.52	$192.75
Beauty Shop Remodel	$846.00	$105.72	$211.44
Beauty Shop Equip	$249.00	$35.52	$65.12
Refroof Cottage	$2,486.00	$165.72	$276.20
Refrigerator	$965.00	$60.96	$60.96
	$428,869.00	$12,713.55	$111,957.55